TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Injured Workers Pharmacy, L.L.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-3504-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The doctor has prescribed these medications with the indication of 'brand name medically necessary,' in some instances abbreviated to 'BNMN…'"

Amount in Dispute: $14,093.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided brand name Percocet based on the prescription from the treating doctor … The requestor provided no documentation from the prescribing doctor, in the patient's medical record, justifying the use of the brand-name drug."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2016 – January 26, 2017	Pharmacy Services – Percocet 10-325 mg tablets	$14,093.48	$14,091.53

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmacy services.
3. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 790 – The charge was reimbursed in accordance to the Texas Medical Fee Guideline.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration
- CAC-91 – Dispensing fee adjustment.
- 437 – Payment for the dispensed pharmaceuticals was made at the generic equivalent average price.
- 517 – Reviewed pursuant to Rule 134.503.

Issues

1. Are Texas Mutual Insurance Company's reasons for reduction of payment supported?
2. What reimbursement is recommended for the disputed services?

Findings

1. Injured Workers Pharmacy, L.L.C. is seeking additional reimbursement of $14,093.48 for Percocet 10-325 mg tablets dispensed from August 11, 2016, through January 26, 2017.

   Texas Mutual Insurance Company (Texas Mutual) reduced the billed charges with claim adjustment reason codes CAC-P12 – "WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT," and 790 – "THE CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE." Dates of service September 8, 2016; November 3, 2016; December 1, 2016; December 28, 2016; and January 26, 2017 include claim adjustment reason codes 437 – "PAYMENT FOR THE DISPENSED PHARMACEUTICALS WAS MADE AT THE GENERIC EQUIVALENT AVERAGE PRICE," and 517 – "REVIEWED PURSUANT TO RULE 134.503."

   In its position statement, Texas Mutual argued that "The requestor provided no documentation from the prescribing doctor, in the patient's medical record, justifying the use of the brand-name drug." 28 Texas Administrative Code §134.503(h) states, "When the prescribing doctor has written a prescription for a brand name drug in accordance with §134.502(a)(3) of this title, reimbursement shall be in accordance with subsection (c) or (f) of this section."

   28 Texas Administrative Code §134.502(a)(3) states:

   > The doctor shall prescribe generic prescription drugs when available and clinically appropriate. **If in the medical judgment of the prescribing doctor a brand-name drug is necessary, the doctor must specify on the prescription that brand-name drugs be dispensed in accordance with applicable state and federal law** [emphasis added], and must maintain documentation justifying the use of the brand-name drug, in the patient's medical record.

   Review of the submitted documentation finds that the prescribing doctor specified that the brand-name drug is medically necessary on the prescription. Documentation submitted by Injured Workers Pharmacy, L.L.C. also includes a Letter of Medical Necessity, dated May 8, 2017, indicating that Dr. Samuel J. Alianell stated that the "generic is non-effective."

   The division finds that Texas Mutual's reasons for reduction of the disputed services is not supported.

   28 Texas Administrative Code §134.503(c)(1) states in pertinent part:

   > (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   > (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   > (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   > (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   > (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or

(2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    (A) health care provider; or
    (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

Reimbursement for the disputed services is calculated below:

Date of Service	Price per Unit	Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
8/11/16	$19.2938	180	($19.2938 x 180 x 1.09) + $4.00 = $3,789.44	$3,789.44	$3,789.44
9/8/16	$19.2938	150	($19.2938 x 150 x 1.09) + $4.00 = $3,158.54	$3,158.54	$3,158.54
11/3/16	$19.2938	150	($19.2938 x 150 x 1.09) + $4.00 = $3,158.54	$3,158.54	$3,158.54
12/1/16	$19.2938	120	($19.2938 x 120 x 1.09) + $4.00 = $2,527.63	$2,527.63	$2,527.63
12/28/16	$19.2938	120	($19.2938 x 120 x 1.09) + $4.00 = $2,527.63	$2,527.63	$2,527.63
1/26/17	$19.2938	120	($19.2938 x 120 x 1.09) + $4.00 = $2,527.63	$2,527.63	$2,527.63
				Total	17,689.41

The total allowable for the disputed services is $17,689.41. Per submitted Explanations of Benefits, Texas Mutual reimbursed $3,597.88. An additional reimbursement of $14,091.53 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $14,091.53.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $14,091.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	October 6, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.